

APPENDIX 17
INSTRUCTIONS FOR COMPLETION OF THE
NATIONAL UB-92 CLAIM FOR HOME HEALTH SERVICES

These instructions may be used in conjunction with the UB-92 Billing Manual prepared by the State Uniform Billing Committee (SUBC). The UB-92 Billing Manual contains important coding information not available in these instructions. A copy of the UB-92 Billing Manual may be obtained from the Wisconsin Hospital Association (WHA). Refer to Appendix 3 of Part A of the Wisconsin Medical Assistance Program (WMAF) Provider Handbook for the address and telephone number of the WHA.

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate item. Do not include attachments unless instructed to do so. All items are required unless "optional" or "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAF) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ITEM 1 - PROVIDER NAME, ADDRESS & TELEPHONE NUMBER

Enter the name, address, city, state, and zip code of the billing provider.

ITEM 2 - UNLABELED FIELD (not required)

ITEM 3 - PATIENT CONTROL NUMBER (optional)

Provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of 17 characters for paper, electronic, or tape claims).

ITEM 4 - TYPE OF BILL

Enter a three-digit code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Home Health/Personal Care providers must use bill type 33X. The third digit ("X") indicates the billing frequency and should be assigned as follows:

- 1 = Inpatient admit through discharge claim
- 2 = Interim bill - first claim
- 3 = Interim bill - continuing claim
- 4 = Interim bill - final claim

ITEM 5 - FEDERAL TAX NUMBER (not required)

ITEM 6 - STATEMENT COVERS PERIOD (FROM - THROUGH) (not required)

ITEM 7 - COVERED DAYS (not required)

ITEM 8 - NONCOVERED DAYS (not required)

ITEM 9 - COINSURANCE DAYS (not required)

ITEM 10 - LIFETIME RESERVE DAYS (not required)

ITEM 11 - UNLABELED FIELD (not required)

ITEM 12 - PATIENT NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ITEM 13 - PATIENT'S ADDRESS (not required)

ITEM 14 - PATIENT'S DATE OF BIRTH (not required)

ITEM 15 - PATIENT'S SEX (not required)

ITEM 16 - MARITAL STATUS (not required)

ITEM 17 - DATE OF ADMISSION (not required)

ITEM 18 - HOUR OF ADMISSION (not required)

ITEM 19 - TYPE OF ADMISSION (not required)

ITEM 20 - SOURCE OF ADMISSION (not required)

ITEM 21 - DISCHARGE HOUR (not required)

ITEM 22 - PATIENT STATUS (not required)

ITEM 23 - MEDICAL/HEALTH RECORD NUMBER (optional)

This number will not appear on the Remittance and Status Report.

ITEM 24-30 - CONDITION CODES

If appropriate, enter a code to identify conditions relating to this claim that may affect payer processing.

| <u>Code</u> | <u>Explanation of Code</u> |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01 | <i>Military service related:</i> Medical condition incurred during military service. |
| 02 | <i>Condition is employment related:</i> Patient alleges that medical condition is due to environment/events resulting from employment. |
| 03 | <i>Recipient covered by insurance not reflected here:</i> Indicates that the patient or a representative has stated that coverage may exist beyond that reflected on this bill. |
| 05 | <i>Lien has been filed:</i> Provider has filed legal claim for recovery of funds potentially due a recipient as a result of legal action initiated by or on behalf of the patient. |
| 08 | <i>Beneficiary would not provide information concerning other insurance coverage:</i> Enter this code if the beneficiary would not provide information concerning other insurance coverage. |

See UB-92 Billing Manual for additional codes.

ITEM 31 - UNLABELED FIELD (not required)

ITEM 32-35(a-b) - OCCURRENCE CODES AND DATES

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format.

| <u>Code</u> | <u>Explanation of Code</u> |
|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01 | <i>Auto Accident:</i> Code indicating the date of an auto accident. |
| 02 | <i>Auto Accident/No Fault Insurance:</i> Code indicating the date of an auto accident where the state has applicable no fault liability laws. |
| 03 | <i>Accident/Tort Liability:</i> Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. |
| 04 | <i>Accident/Employment Related:</i> Code indicating the date of an accident relating to the patient's employment. |
| 05 | <i>Other Accident:</i> Code indicating the date of an accident not described by the above codes. |
| 06 | <i>Crime Victim:</i> Code indicating the date on which a medical condition resulted from allegedly criminal action committed by one or more parties. |
| 25 | <i>Date Benefits Terminated by Primary Payer:</i> Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient. |
| 42 | <i>Date of Discharge:</i> For final bill of hospice care, enter the date the beneficiary terminated the election of hospice care. |

See UB-92 Billing Manual for additional codes.

ITEM 36(a-b) - OCCURRENCE SPAN CODE AND DATES (not required)

ITEM 37 - INTERNAL CONTROL NUMBER (ICN)/DOCUMENT CONTROL NUMBER (DCN) (not required)

ITEM 38 - RESPONSIBLE PARTY NAME AND ADDRESS (not required)

ITEM 39-41(a-d) - VALUE CODES AND AMOUNTS

If appropriate, enter a value code and the related dollar amount necessary for processing this claim. The value code structure is intended to provide additional reporting capabilities.

| <u>Code</u> | <u>Explanation of Code</u> |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 22 | <i>Surplus:</i> spenddown required to be entered if patient spenddown occurs. This code should be entered together with the dollar amount. |

ITEM 42 - REVENUE CODE

Enter revenue code 001 on the last line, indicating the line on which the sum of all charges on the claim is placed.

ITEM 43 - REVENUE DESCRIPTION

Enter the date of service in the MMDDYY format either in this item or in Item 45.

When series billing (i.e., billing from two to four dates of service on the same line), indicate the dates of service in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four dates of service for each revenue or procedure code if:

- All dates of service are in the same calendar month.

- All procedures performed are identical.
- All procedures were performed by the same provider.

If billing a range of dates for the rental of durable medical equipment (DME), the range of dates must be within a single calendar month and indicated in the following manner: MMDDYY - MMDDYY.

If it is necessary to indicate more than four dates of service per revenue or procedure code (except for DME rentals with a range of dates), indicate the dates on subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim, including the "total charges" line.

ITEM 44 - HCPCS/RATES

Enter the appropriate five-digit procedure code.

If billing for DME, indicate the appropriate procedure code followed by a hyphen and the type of service (TOS) code "P" for a purchase or "R" for a rental.

ITEM 45 - SERVICE DATE

Enter the date of service in the MMDDYY format either in this item or in Item 43. (Multiple dates of service must be indicated in Item 43.)

ITEM 46 - UNITS OF SERVICE

Enter the total number of services.

ITEM 47 - TOTAL CHARGES

Enter the total charge for each line item. For revenue code 001 (total charges), enter the grand total for all services submitted on the claim.

ITEM 48 - NONCOVERED CHARGES (not required)

ITEM 49 - UNLABELED FIELD (not required)

ITEM 50 - PAYER IDENTIFICATION

Indicate the WMAP ("T19-WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. All coverages indicated on the recipient's Medical Assistance identification card must be addressed.

ITEM 51 - PROVIDER NUMBER

Enter the provider's eight-digit provider number on the "T19-WI Medicaid" line.

ITEM 52 - RELEASE INFORMATION CERTIFICATION INDICATOR (not required)

ITEM 53 - BENEFITS ASSIGNED (not required)

ITEM 54 - PRIOR PAYMENTS-PAYER AND PATIENTS

If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter \$0.00. (Do not indicate Medicare payments.)

File an "Other Coverage Discrepancy Report" (Appendix 19 of Part A of the WMAP Provider Handbook) if coverage listed on the recipient's Medical Assistance identification card disagrees with the recipient's statement.

ITEM 55 - ESTIMATED AMOUNT DUE (not required)

ITEM 56 - UNLABELED FIELD (not required)

ITEM 57 - UNLABELED FIELD (not required)

ITEM 58 - INSURED'S NAME (not required)

ITEM 59 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ITEM 60 - CERTIFICATE NUMBER, SOCIAL SECURITY NUMBER, HEALTH INSURANCE CLAIM NUMBER IDENTIFICATION NUMBER

On the "T19-WI Medicaid" line, enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

ITEM 61 - INSURED GROUP NAME (not required)

ITEM 62 - INSURANCE GROUP NUMBER (not required)

ITEM 63 - TREATMENT AUTHORIZATION CODE

On the "T19-WI Medicaid" line, enter the seven-digit prior authorization number from the approved Prior Authorization Request Form. Services authorized under separate prior authorization numbers must be billed on separate claim forms with their respective prior authorization numbers.

ITEM 64 - EMPLOYMENT STATUS CODE (not required)

ITEM 65 - EMPLOYER NAME (not required)

ITEM 66 - EMPLOYER LOCATION (not required)

ITEM 67 - PRINCIPAL DIAGNOSIS CODE

The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. Manifestation ("M") codes are not valid diagnosis codes for Medical Assistance.

ITEMS 68-75 - OTHER DIAGNOSIS CODES

Enter the full ICD-9-CM diagnosis codes corresponding to additional conditions related to treatment billed on the claim. Other diagnosis codes will permit the use of ICD-9-CM "E" codes. Manifestation ("M") codes are not valid diagnosis codes for Medical Assistance.

ITEM 76 - ADMITTING DIAGNOSIS (not required)

ITEM 77 - EXTERNAL CAUSE OF INJURY (E-CODE) (not required)

ITEM 78 - RACE/ETHNICITY (not required)

ITEM 79 - PROCEDURE CODING METHOD USED (not required)

ITEM 80 - PRINCIPAL PROCEDURE CODE AND DATE (not required)

ITEM 81(a-e) - OTHER PROCEDURE CODES AND DATES (not required)

ITEM 82(a-b) - ATTENDING PHYSICIAN ID

Enter the attending physician's name and UPIN number or eight-digit Medical Assistance provider number.

ITEM 83(a-b) - OTHER PHYSICIAN ID (not required)

ITEM 84 - REMARKS

Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAF, unless the service does not require third-party billing according to Appendix 18a of Part A of the WMAF Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of the WMAF Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.
- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAF Provider Handbook, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

| <u>Code</u> | <u>Description</u> |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| OI-P | PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim. |
| OI-D | DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to the private insurer. |
| OI-Y | YES, card indicates other coverage but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none">- Recipient denies coverage or will not cooperate;- The provider knows the service in question is noncovered by the carrier;- Insurance failed to respond to initial and follow-up claim; or- Benefits not assignable or cannot get an assignment. |
| - | When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable: |

| <u>Code</u> | <u>Description</u> |
|-------------|-------------------------------------------------------------------------------------------------------------------|
| OI-P | PAID by HMO or HMP. The amount paid is indicated on the claim. |
| OI-H | HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount. |

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAF except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAF for services which are included in the capitation payment.

Medicare must be billed prior to billing the WMAF. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is required.

| <u>Code</u> | <u>Description</u> |
|-------------|--------------------|
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|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| M-1 | Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime of its coverage. |
| M-5 | Provider not Medicare certified for benefits provided. |
| M-6 | Recipient not Medicare eligible. |
| M-7 | Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted. |
| M-8 | Medicare was not billed because Medicare never covers this service. |

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Medicare Remittance Advice (RA) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlements.

ITEM 85 - PROVIDER REPRESENTATIVE SIGNATURE

The provider or the authorized representative must sign in item 85. This may be a computer printed name or a signature stamp.

ITEM 86 - DATE BILL SUBMITTED

Enter the date on which the claim is submitted to Medical Assistance in the MMDDYY format.

APPENDIX 17a
SAMPLE NATIONAL UB-92 CLAIM FORM
PRIVATE DUTY NURSING

| 1 I.M Billing Provider 1 W Wilson Anytown WI 55555 (222) 333-444 | | 2 | 3 PATIENT CONTROL NO JED1234 | | 4 | |
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| 96 | 97 | 98 | 99 | 100 | 101 | 102 |
| 12 PATIENT NAME Recipient Im A | | 13 PATIENT ADDRESS | | | | |
| 14 BIRTHDATE | 15 SEX | 16 MS | 17 DATE | 18 MO | 19 YR | 20 SEC |
| 21 D HR | 22 STAT | 23 MEDICAL RECORD NO | 24 | | | |
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| 973 | | 974 | | 975 | | 976 |
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| 981 | | 982 | | 983 | | 984 |
| 985 | | 986 | | 987 | | 988 |
| 989 | | 990 | | 991 | | 992 |
| 993 | | 994 | | 995 | | 996 |
| 997 | | 998 | | 999 | | 1000 |

UB-92 HCFA-1450

OCR/Original

85 PROVIDER REPRESENTATIVE
X-2 to Authorize 08/09/98

86 DATE

87 CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

| | | | | | | | | | | | |
|------------------------------------------|--|----------------------------------------|--|------------------------------|--|---------------------------------|--|---------------------------------|--|----------------------|--|
| I M Billing Provider | | | | | | | | APPROVED OMB NO. 0938-0078 | | | |
| 1 W Wilson | | | | | | | | 3 PATIENT CONTROL NO JED 1234 | | | |
| (222) 333-4444 | | | | | | | | 3 TYPE OF BILL 332 | | | |
| 5 FED TAX NO | | 6 STATEMENT COVERS PERIOD FROM THROUGH | | 7 COV D | | 8 NCD | | 9 C/D | | 10 L/RD | |
| | | | | | | | | | | | |
| 12 PATIENT NAME Recipient Im A | | | | 13 PATIENT ADDRESS | | | | | | | |
| 14 BIRTHDATE | | 15 SEX 16 MS | | 17 DATE | | ADMISSION 18 HRS 19 TIME 20 DAY | | 21 DHR 22 STAT | | 23 MEDICAL RECORD NO | |
| | | | | | | | | | | | |
| 30 OCCURRENCE DATE | | 31 CODE | | 32 OCCURRENCE DATE | | 33 CODE | | 34 OCCURRENCE SPAN FROM THROUGH | | 35 CODE | |
| | | | | | | | | | | | |
| 36 VALUE CODES AMOUNT | | 37 CODE | | 38 VALUE CODES AMOUNT | | 39 CODE | | 40 VALUE CODES AMOUNT | | 41 CODE | |
| | | | | | | | | | | | |
| 42 REV CD | | 43 DESCRIPTION | | 44 HCPCS / RATES | | 45 SERV DATE | | 46 SERV UNITS | | 47 TOTAL CHARGES | |
| 001 | | 07/09/93 | | W9930 | | | | 1.0 | | XX XX XX XX | |
| | | | | | | | | | | | |
| 50 PAYER | | 51 PROVIDER NO | | 52 REL INFO | | 53 ASS SERV | | 54 PRIOR PAYMENTS | | 55 EST AMOUNT DUE | |
| T-19 WI Medicaid | | 12345678 | | | | | | | | | |
| 57 | | DUE FROM PATIENT ▶ | | | | | | | | | |
| 58 INSURED'S NAME | | 59 P REL | | 60 CERT - SSN - MC - ID NO | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | | |
| | | | | 1234567890 | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | | 64 ISC | | 65 EMPLOYER NAME | | 66 EMPLOYER LOCATION | | | | | |
| 1234567 | | | | | | | | | | | |
| 67 PRIN DIAG CD | | 68 CODE | | 69 CODE | | OTHER DIAG CODES 70 CODE | | 71 CODE | | 72 ADM DIAG CD | |
| 436 | | | | | | | | | | 73 E-CODE | |
| 79 P.C. | | 80 PRINCIPAL PROCEDURE CODE DATE | | 81 OTHER PROCEDURE CODE DATE | | 82 ATTENDING PHYS ID | | 65432100 | | | |
| | | | | | | | | | | | |
| | | OTHER PROCEDURE CODE DATE | | OTHER PROCEDURE CODE DATE | | 83 OTHER PHYS ID | | | | | |
| | | | | | | | | | | | |
| 84 REMARKS | | | | | | OTHER PHYS ID | | | | | |
| | | | | | | | | | | | |
| | | | | | | 85 PROVIDER REPRESENTATIVE | | 86 DATE | | | |
| | | | | | | X-18 to Anthony's | | 08/09/93 | | | |

UB-92 HCFA-1450 OCR/Original I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPENDIX 17c
SAMPLE NATIONAL UB-92 CLAIM FORM
HOME HEALTH AIDE SERVICES

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------|--|-----------------------|--|------------------------------------------|--|-------------------------------------|--|-------------------------------------------------------------------------------------------|--|---------|--|------------------|--|-----------|--|----|--|----|--|----|--|----|--|----|--|----|--|
| 1 I M Billing Provider 1 W Wilson Anytown WI 55555 (222) 333-4444 | | 2 | | 3 PATIENT CONTROL NO. JED 1234 | | 4 TYPE 332 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 FED TAX NO. | | 6 STATEMENT COVERS PERIOD FROM | | 7 COVD | | 8 N-CO | | 9 C-ID | | 10 L-R-D | | 11 | | | | | | | | | | | | | | | | | | | |
| 12 PATIENT NAME | | | | 13 PATIENT ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 BIRTHDATE | | 15 SEX | | 16 MS | | 17 DATE | | ADMISSION 18 MS 19 DAY 20 MON 21 YEAR | | 22 STAT | | 23 MEDICAL RECORD NO. | | 24 | | 25 | | 26 | | 27 | | 28 | | 29 | | 30 | | 31 | | | |
| 32 OCCURRENCE CODE | | 33 OCCURRENCE DATE | | 34 OCCURRENCE CODE | | 35 OCCURRENCE DATE | | 36 OCCURRENCE SPAN FROM | | 37 OCCURRENCE THROUGH | | 38 | | 39 | | 40 | | 41 | | 42 | | 43 | | 44 | | 45 | | 46 | | 47 | |
| 42 REV. CD | | 43 DESCRIPTION | | 44 HCPCS / RATES | | 45 SERV. DATE | | 46 SERV. UNITS | | 47 TOTAL CHARGES | | 48 NON-COVERED CHARGES | | 49 | | | | | | | | | | | | | | | | | |
| 001 | | 07/13/93 07/13/93, 07/14, 07/15, 07/16 07/17/93, 07/13, 07/20 | | W9930 W9931 W9931 | | | | 1.0 4.0 3.0 | | XX XX XXX XX XXX XX XXX XX | | | | | | | | | | | | | | | | | | | | | |
| 50 PAYER | | 51 PROVIDER NO. | | 52 REL. INFO | | 53 ASS. BTH | | 54 PRIOR PAYMENTS | | 55 EST. AMOUNT DUE | | 56 | | | | | | | | | | | | | | | | | | | |
| T-19 WI Medicaid | | 12345678 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 57 | | DUE FROM PATIENT ▶ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58 INSURED'S NAME | | 59 P-REL | | 60 CERT. - SSN - HIC - ID NO. | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | 1234567890 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | | 64 ESC | | 65 EMPLOYER NAME | | 66 EMPLOYER LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1234567 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 67 PRIN. DIAG. CD | | 68 CODE | | 69 CODE | | 70 OTHER DIAG. CODES | | 71 CODE | | 72 CODE | | 73 CODE | | 74 CODE | | 75 ADM. DIAG. CD | | 76 E-CODE | | 77 | | | | | | | | | | | |
| 436 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 79 P-C | | 80 | | 81 | | 82 | | 83 | | 84 | | 85 | | 86 | | 87 | | 88 | | 89 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 84 REMARKS | | | | | | | | | | | | 85 PROVIDER REPRESENTATIVE | | 86 DATE | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | X S M Authorized | | 08/093 | | | | | | | | | | | | | | | | | |
| UB-92 HCFA-1450 | | OCR/Original | | | | | | | | | | I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF | | | | | | | | | | | | | | | | | | | |

The field numbers on the ECS screen correspond with the numbered data elements on the UB-82 claim form

| | | | | | | | | | |
|--------|----|--------|----|--------|----|-----|----------|-----|----------|
| PROV | 8 | L NM | 10 | F NM | 10 | MID | 68 | | |
| PCN | 3 | MSC | 94 | OI | 94 | OCC | 28 29 30 | CND | 35 36 37 |
| AP NBR | 92 | OP NBR | 93 | PA NBR | 91 | | | | |
| VALUE | 46 | | 47 | | 48 | | | 49 | |
| DIAG | 77 | 78 | 79 | 80 | 81 | | PRIOR | PMT | 63 |

[illegible]

04-18-1992 10:14:01

- bill type
- recipient's date of birth
- recipient's address
- recipient's sex
- signature of provider
- provider's name and address

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section 4 of the handbook, or fill out the Paperless Claim Request form located at the back of this handbook.